Optional Working Session
The Working Group to Reinvent Medicaid
Wednesday June 3, 2015
7:30am – 8:30am

Rick Jacobsen, Deb Faulkner, Colleen McCarthy, John Andrews, Tom Pearson, Lynn August, Patrice Cooper, Jenny Hayhurst, Paco Trilla, Elizabeth Burke Bryant, Al Kurose, Sam Salganik, Garry Bliss, Hugh Hall, Peter Andruszkiewicz, Brenda Whittle, Deidre Gifford, Holly Cekala, Matthew Harvey, Secretary Roberts

I. Welcome – Dennis Keefe
II. Presentation by Deidre Gifford – Considerations in Moving to an ACO Strategy in RI (Presentation available on website and upon request
    a. Secretary Roberts: In our current environment where do ACOs live on the path on the grid on slide number seven?
    Al Kurose: We are shared savings one sided risk, though we point out there are incremental costs involved so in real life there is risk involved.
    Dennis Keefe: We are track one and track three, but also in Medicare advantage with Blue Cross, a full capitation structure.
    Peter Andruszkiewicz: We have multiple risk arrangements, some two-sided, none full capitation.
    Jenny Hayhurst: United has three.
    Paco Trilla: Neighborhood Health Plan has been working with the community health centers for years as at live risk and at risk with methodology for two years.
III. Presentation by Deb Faulkner: Accountable Care Organizations: Learnings from Other States (Presentation available on website and upon request).
    a. Elizabeth Burke Bryant: How do you measure success?
    Deb Faulkner: States define it differently depending on goals. They pick a few key measures that they want to change, and then those fall down to the provider groups holding accountable to. Then those metrics are pulled out of the provider groups to try to hit the overall goals. There is a higher level measure of objectives. It is early to tell how they are doing – Oregon has some early measures of interim success, showing all of their ACOs, showing where they were before, where they are now; early success.
    b. Secretary Roberts: Are they all designed to focus on the same metrics?
    Deb Faulkner: there is a standard set of metrics with some variation at the provider group level. Depending on the provider group.
    c. Sam Salganik: What about providers not in the ACO, are they required to join, how being paid?
    Deb Faulkner: I can speak a little to Oregon, who say that's it that's the network. Minnesota says we have the ACOs, you still contract with the MCOs as they are alongside of that. Those not a part of the ACO are

still part of the MCO as they were before. It is alongside so not forcing change to the rest of the provider group as quickly. Oregon says in or out.

d. Al Kurose: A lot of the focus is on affordability and cost performance and the things mentioned sound more like buckets of utilizations. Have those been tied to financials and see?
   Deb Faulkner: Say they have a total cost of care objective, but have a set of metrics around quality, they then do a cross multiplying process. Providers need to report on the metrics, and if you report and achieve cost goals, you get 100% of the cost savings. It is not always a clean multiplier but it is a multiplier.
   Al Kurose: Yes, but that is the provider incentives, so what is the state?
   Deidre Gifford: With the case of Oregon, in Medicaid the federal government is also a partner, and what Oregon did was get a massive waiver of Medicaid rules and promised to CMS that they would save "Y" off the projection of "X", and the delta CMS invested in the development of the system. But the state is at full risk for that delta if they do not perform. They took that risk. They are a year, year and a half in thus uncertain if it works just yet.
e. Dennis Keefe: Is there a structure with the Medicaid MCOs and then an ACO structure in parallel through the ACO does it have to be attribution or membership model?
   Deb Faulkner: Membership model – which to clarify is what the implication for the member, entirely behind the scenes or who you chose as a provider. Mostly so far, it is purely an attribution model, can be done through the MCOs or next to the MCOs, either way the consumer doesn't feel a difference in how they access care.
f. Peter Andruszkiewicz: These entities in the states are in early stages, how far along the journey are they – how long working on this? Secondly, how prescriptive are the states in defining what an ACO is?
   Deb Faulkner: In terms of how prescriptive that runs the gamut. Are the states aligning with what's out there, directing, or stating this is exactly what we want. Oregon has done the latter. In Minnesota, it's more mixed they had existing entities out there and put more guidance out there. There are many states that just said Medicare is doing this, I am going to match my requirements to the Medicare requirements and let the market define.
   Deidre Gifford: It is a predictable distribution of how states are thinking about it depending on the political philosophy of the state.
   Deb Faulkner: To your first question, Peter, they are all pretty different and it depends on their starting point. Minnesota had existing integrated delivery systems and really developed metrics to start with an established base of data to hold the entities accountable. Without those two things in place that is a tougher starting point.

Without performance metrics I cannot say who has performed better, but Oregon and Minnesota appear to be moving along.

g. Secretary Roberts: Isn't Oregon about five years down the timeline?
   Deb Faulkner: I do not have a solid handle on all of the timelines associated with this, given the historical build up.
   Deidre Gifford: A lot of the specifics of our 1115 waiver would need to be retooled.
h. Hugh Hall: What is a RCCO as referenced on the slides?
   Deb Faulkner: Regional Coordinated Care Organization
i. Paco Trilla: The ACOs were set up for a variety of patients, but do we have any idea how these states are handling pediatrics?
   Deb Faulkner: I have not seen a lot of data on programs for children. Not to say it does not exist, but would need follow up
j. Sam Salganik: Care coordination seems like there is an opportunity to save money there. Yet in the past we have seen attempts at this are care stinting, or other undesirable means of saving money. In other states and models have you seen good examples of adjusting for this?
   Deb Faulkner: Even if some providers are stinting on care it would be detected as the providers here need to be held to performance metrics which make that clear. Needs to be clearer in the model.
k. Secretary Roberts: Are there some focused on particular unique populations?
   Deb Faulkner: Most what I have seen are regionally based, but there are some that are specific to unique populations – I know Minnesota has one. There are small almost pilot-like focused on services, but not ones you read as much about.
   Secretary Roberts: A regional approach. Most of the regions in other states are the size of RI, so then how does that work? Arbitrarily assigned? How is it handled in eastern Massachusetts?
   Dennis Keefe: Massachusetts is interesting in that the state has been clever in moving the risk to the MCOs, there is an actuary process, but then the MCOs are largely left to their own devices. In terms of special populations there are special rate bands to deal with those, thus not one premium fits all, and different strategies within those rate bands. It is left up to the MCOs whether they want to carve behavioral health out or if it should be in; I feel it should be in. Want to incentivize the provider community based on the relationship. By and large it's a model that if the MCO performs well, then they do well.
l. Jenny Hayhurst: Are budgets ever benefit cost ratio (BCR) based?
   Deb Faulkner: I am sure there are all sorts of models.
   Jenny Hayhurst: In our programs we might use that, more like a Medicare program.
   Deidre Gifford: For us a point of importance around measuring total cost of care is that our plans don't have the total benefit package within them. On reason Minnesota may have (slide 11) done this – today a child in RIte Care has coverage through an MCO but for some

of the more expensive costs the service is through FFS, so the MCO has not all of their costs. The point is just being that for an entity to be totally responsible for total cost of care with no carve outs we need to have a full picture of the cost to the MCO, plus the reasoning why in past pieces had been carved out to the state.
Deb Faulkner: In Minnesota, if you are attributed to this provider group, that is what you are responsible towards. There is a standard, not five different set of rules with different carriers, but rather one set of rules for one provider group; there is still some managed care, but also this entity has some requirements that the provider level rather than the carrier level.
Patrice Cooper: That is not that far off from where we are with the state now, not as much incentive, but I understand where you are coming from.

m. Secretary Roberts: How have they dealt with Long Term Care?
Deidre Gifford: It is carved out in Oregon, they tried to get it carved in and they failed.
Paco Trilla: Minnesota carved out LTSS and behavioral health; since RI is trying to make it all work we are a bit ahead.
Rick Jacobsen: This conversation is a bit of a microcosm of questions we have tried to address over time. We have been looking at structural context thus far.
n. Dennis Keefe: The thing I find attractive about RI is the fact that so many individuals are already in a managed care relationship, then it sets us up to do a lot. One of the benefits of managed care populations is the churn. It's a member model: deal with the churn better and be more successful. One of the problems in MA was that the MCO models were doing well, but I do not think they took on the idea that Medicaid members can opt out. Could put together a better model based on our history. If we did an ACO model with BCBSRI for example, the members would pick a product, perhaps the ACO product, then they have to play by the rules of the ACO, but have a primary care physician, a member of the ACO, care managed through that ACO because they are members, and the attribution model – would have to do indirect measures to manage the population.
Deidre Gifford: A critical element, from our federal partners' perspective, choice is very key to them when it comes to managed care. We would have to justify and explain how members would have choice. In the past, CMS has required choice at the MCO level. Now, they are beginning to focus on choice at the ACO level. In California, there is a single MCO, but eleven provider networks – CMS allows for that single plan as there is choice within that plan through those provider networks.
o. Al Kurose: On the churn question, did any groups in Massachusetts use the continuous enrollment method?
Denis Keefe: Not at the point I left.

Al Kurose: That was something that we tinkered with, but it has pros and cons.

p. Patrice Cooper: Not a lot of churn "churn." Many out of the system, we don't even see a lot of movement during open enrollment. The churn around providers is more around primary care physicians.
q. Brenda Whittle: In the model where you attribute people and they need to go to a set place, if they go somewhere else do you deny payment to the provider? That can create provider dissatisfaction, always assigned a patient a primary care home, we have not specifically denied the claim if they get care elsewhere.
Secretary Roberts: Going back a few years, if you went to another provider and the care was non-emergent, they did not pay the claim; it was a closed network. You could choose a different plan, but if you did go into that plan they wouldn't pay if you went elsewhere. We did have it here years ago.
Brenda Whittle: Right, there are many providers here around the table happy to be paid if a member moves.
Patrice Cooper: The concept of non-payment was there, however.
Secretary Roberts: Part of the conversation about an ACO might be a conversation about an integrated model –will there be that tight model? We need to discuss what happened and what could happen again.
Deb Faulkner: It really does feel like a spectrum – at one end have purely attributed where the member sees none of this, all the way to the other end where a member indicates 'I am picking this ACO as my product, closed network, or if out of network I will need to pay out of pocket.' Could have them alongside one another, it's a possibility.
Paco Trilla: This works partly because the Medicare ACO has evolved. You have an idea of when a patient is seen, but the even-ing up is after the fact.
r. Elizabeth Burke Bryant: This has been very illuminating, this is a very evolving set of things going on across the country and states are looking at what they have as their base and what are they building from, and it seems there is no singular right answer. Have other states looked at special populations? What care management we know is needed in some areas, we should look at our strengths as reviewing the best approach for each state. What are the opportunity moments we have in RI given our makeup, instead of replicating another state's model.

IV. Conversations

a. Al Kurose: When I am looking at this it makes me think about where are the Medicaid members distributed today – who takes care of them? You can speak theoretically, but what does that distribution look like. Is it homogenous performance you are seeing? Maybe the strategy for how to go ahead has to depend on a more specific and nuanced understanding of what the provider readiness is – where are

the patients today, how do those organizations perform, are they mostly in these groups…? If talking about ACOs, forming a greater focus on the provider delivery of care would be things I would all factor in in looking at what levers to use. All the work done here is important, but ACOs are formed by providers, policy, regulations and incentives cannot force them to happen. I think knowing what exists would help to be strategic about what choices to make. As far as Coastal is concerned today we have 8500 Medicaid members, it is an active project to understand how they are distributed. One of the issues we have is capacity, we had this covered a few years ago – a few docs have retired, some have stepped back due to personal illness – thus some practices do not have the capacity. Everyone is experiencing an issue with taking on new members. If thinking too about redistribution – do we want ACOs to become a big piece of delivery system – that may be a capacity issue?

b. Dennis Keefe: The train, to me, has left the station largely in healthcare delivery reform. These ACOs are the future: how do we get to that point in the future. Trying to meet people where they are is very relevant. Oregon's governance was governance on steroids; the Medicare governance model to me seems to be a good model. We [at Care New England) have thousands of Medicaid members already, looking to expound on that. This is big business, yet you have to do everything we have heard around the table to be successful. One analogy is that we are building the aircraft in flight, given our financial risk; the other analogy is turning around the aircraft carrier – you don't feel as if you have moved but if you step back you see much progress has been made. Need to assess the quality part with the financial part. For me three major principals for success for an ACO: Care management, care management and care management. Those are the skills we are trying to develop with our provider partners. For me the biggest question for the state is this idea that if there is going to be an ACO overall direction, how do you get there. Is it next to the MCOs, through the MCOs, that is the big policy question, for how that gets decided changes how you approach different items.
c. Paco Trilla: I want to agree with you, Dennis, on a lot of points. I think the MCOs are in a position to evaluate cost of care and care management. I can look at our members and tell you, for Medicaid payments with providers, where are our populations, where are our successes etc. Al also brought up an important issue of workforce. Training incoming workforce to work within this system, and currently about 50% have no capacity. How do we as a state encourage the development of a new provider pool and population?
d. Jenny Hayhurst: From United's perspective, our ACO is provider centric. We look at where our members are today, and then we look at cost and metrics and see if that provider is ready to go into our program. Our ACO contracts are BCR based and include features

around performance to prevent things like rationing care and require things like weekend and evening access.

e. Dennis Keefe: To me, strongly primary care driven model, with physician extenders – how do you get that primary care provided. I don't think we have spent enough time on the physician payment system and the adequacy of that system. I think there are problems with physicians providing that access. In terms of thinking out of the box, I think the neighborhood health centers are part of the design – anyone trying to be a part of the system to improve health outcomes is working to improve. This is the journey to look over all of this.
f. Secretary Roberts: We have two views: a package, a provider group that wants to come in, take full risk, we can do it, or the other voiced route is we need to build on what we have and create our own. I am interested in the opinions – for those willing to speak in public about it?
g. Peter Andruszkiewicz: I am trying to look at this through the state's perspective, I think the state should do due diligence on an offer of a packaged provider group – if that is where we think we are going, and these models are all different, I think it is a wonderful experiment. I would protect myself for how many members could go into that model but a great experiment for how far and how fast we can go. If I am the state, the proverbial house is on fire and we need to do what we can to help those involved. A few other points, Elizabeth Burke Bryant said it well, it's good to look at other models in other states, but we need to look at RI's model. RI has a unique set of circumstances, delivery system. What are the cost and care, unique utilization? We know in the commercial sphere where it all lies, so when I think about Medicaid it's like two thirds of the cost and total is institutional care. To the question before, about carve outs, I don't know why you would carve out sub-acute care as that is money going out the door. Then finally, the last point, is do you allow the market to determine itself and to evolve itself, or the other end of the spectrum is what an ACO is. I don't know the answer but do need to put it in the lens of the place is on fire and it's not getting better. A difficult policy decision to make but an important one.
h. Secretary Roberts: Some of our house is on fire, not all of our house. The question is how you uniquely focus attention, but at the state time do not create new silos that end up funneling the flames elsewhere around the building.
i. Patrice Cooper: As the products change over time, that may help us model where we go. We haven't seen that evolution yet.
j. Dennis Keefe: I do wish to declare I have a conflict before I make this statement, but I support the marketplace offering these products and being a part of this solution. With Medicaid in particular when you do this you don't want to have a massive failure – the criteria should be the same as the MCOs have: dollars to back up financial risk, the

providers, the access etc. If anyone wants to work in this space the same criteria should apply. Part of the concern here is getting that in place quickly so that you do not lose an opportunity. If the criteria can be developed and put in place, with engagement from other partners, perhaps it could be a part of our recommendations.

k. Garry Bliss: While I also want to state I do have a conflict also, I agree with what Peter was saying regarding urgency of need to ask. We do have capacity and some experience there with a lot of care management, and care management towards outcomes, some capacity to build on, with the ability to link to hospital based care. Do you really have that capacity to really mange more efficiently to achieve the outcomes you want? It's reassuring that on the capacity side not really starting from scratch. Time is of the essence.

V. Public Comment: No additional comment offered at this time

VI. Adjourn